Commissioning complementary medicine

Evaluations of efficacy of treatments should be consistent

EDITOR,—In his editorial Iain Smith calls for research to obtain evidence of the efficacy of complementary procedures, and we agree that "the burden of proof should be no greater, or less, than for mainstream medicine."[1] In the next paragraph, however, he says that randomised controlled trials "may fail to allow for the holistic effect that is central to the philosophy of most complementary therapies" and that "the beneficial effects are often so obvious, the side effects so rare and mild, and the duration of effect so variable after even a single exposure that perhaps observational studies may be enough to prove benefit." He then cites Black, who quotes defibrillation for ventricular fibrillation as an example of a treatment with an impact so large that observational data are sufficient to show it.[2]

We are unconvinced by this argument. In conventional medicine the mildness of side effects or variability in the duration of effects would not be accepted as an excuse for not using a randomised controlled trial to prove efficacy. We cannot think of any complementary treatment that has an impact comparable to that of defibrillation or in which holistic considerations prohibit the use of a randomised controlled trial to prove efficacy, but Smith says that this is "often" the case. Could he please suggest a few examples of complementary treatments that cannot be tested by such trials for the reasons he gives?

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1 Smith I. Commissioning complementary medicine. *BMJ* 1995; 310:1151-2. (6 May.)
2 Black N. Experimental and observational methods of evaluation. *BMJ* 1994;309:540.

Homoeopathic hospitals have unique skill

EDITOR,—Although Iain Smith's editorial on the problems facing health authorities in commissioning complementary medicine mentions several providers of complementary medicine, all of which are either small and local or mostly private, it omits to mention the most important NHS providers of complementary medicine—the homoeopathic hospitals.[1] There are five such hospitals in the NHS; four are parts of larger trusts, while one, the Royal London Homoeopathic Hospital NHS Trust, is a "stand alone" trust.

The homoeopathic hospitals are unique pools of medical skill in complementary medicine with established research records in just the type of research that Smith advocates.[2-4] They are the only dedicated complementary medicine hospitals in the public sector in Europe.[5] Despite their name they do not provide only homoeopathy. The Royal London Homoeopathic Hospital NHS Trust has services covering a wide range of clinical areas, including women's and children's clinics, rheumatology, dermatology, complementary treatment for cancer, back pain, and chronic fatigue. Each service provides a range of complementary treatments for the problems encountered.

The Royal London Homoeopathic Hospital NHS Trust has contracts totalling £1·4m with 26 health authorities covering most of southeast England, has had extracontractual referrals from most health authorities in England and Wales, and has referral arrangements with over 400 general practice fundholders. This is the largest single body of evidence on NHS purchasing practices for complementary treatments, and Smith's opinions would carry more weight had they been based on such evidence. Our evidence, however, bears out the variability of commissioning authorities' purchasing policies to which Smith alludes.

We welcome Smith's call for research and his recognition of some of the problems facing research in complementary medicine, but the argument needs to be taken a step further. In our experience, NHS bodies are reluctant to support such research. Unless this attitude changes, the problems facing commissioning bodies in making purchasing decisions on complementary medicine will multiply.

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1 Smith I. Commissioning complementary medicine. *BMJ* 1995; 310:1151-2. (6 May.)
2 Reilly D, Taylor M, Beattie N, Campbell J, McSharry C, Aitchison T, *et al.* Is the evidence for homoeopathy reproducible? *Lancet* 1994;334:1601-6.
3 Fisher P, Greenwood A, Huskisson EC, Turner P, Belon P. Effect of homoeopathic treatment on fibrositis (primary fibromyalgia). *BMJ* 1989;299:365-6.
4 Clover A, Last P, Fisher P, Wright S, Boyle H. Complementary cancer therapy: a pilot study of patients, therapies and quality of life. *Complementary Therapies in Medicine* (in press).
5 Fisher P, Ward A. Complementary medicine in Europe. *BMJ* 1994;309:107-11.

Structural adjustment and health

Mission hospitals are a useful model

EDITOR,—The excellent leading article in which Angela Wakhweya describes the results of socioeconomic adjustment on the health of women and children rings true for Africa, but only one mention is made of mission hospitals.[1] No mention is made of district hospitals, which are centres from which community care reaches out and to which patients with more serious problems can be referred.

For over 100 years mission hospitals have provided this kind of district hospital service, in some countries offering a significant proportion of the total health care available. They have been staffed partly by expatriate nurses, doctors, and paramedics who often stay long term and therefore become familiar with the language and culture of the local community and the particular medical and surgical skills required. The Christian Medical Fellowship has around 280 members working as doctors in developing countries and many work in such hospitals. Some are employed by multilateral, bilateral, and non-government organisations,[2] but others are employed directly by national governments and churches.

Because mission and church related hospitals face particular economic constraints their staff become skilled at providing appropriate medical care in a cost effective way. Their team spirit means they are often well motivated to do so. They can achieve a high degree of accountability because their expatriate members are free from the pressures that nationals experience from their own communities and because the expatriates represent the donor countries. Those planning overseas aid should take a longer look at mission and church related hospitals.

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1 Wakhweya AM. Structural adjustment and health. *BMJ* 1995;311:71-2. (8 July.)
2 Johnstone P. How to work in a developing country. *BMJ* 1995;311:113-5. (8 July.)

Financial institutions must let go

EDITOR,—Angela Wakhweya has asked us to "require those who wield economic power not to do so with total disregard for . . . mothers and children."[1] Who actually wields economic power? Clearly, when the people of the developing nations paid $100bn between 1986 and 1991 to private financial institutions, these institutions wield considerable power.

The World Health Organisation's 1995 report, *Bridging the Gap*, described the "disproportionate flow of resources from the developing to the developed world—poor countries paying money to rich ones—because of debt servicing and repayment."[2] But these resources did not just naturally "flow" from one country to another. The directors of the financial companies used their economic power to make sure that the $100bn moved the way they did. This money did not go to "rich countries"; it did not go to the people of those countries. It went into the accounts of those companies and their shareholders.

The directors want the money—$20bn a year—to keep on coming. So, through financial institutions like the International Monetary Fund, they impose structural adjustment policies, which always "adjust" welfare provision downwards. But, as the WHO report said, "Investing in health saves money as well as lives. It must be accepted that expenditure on health is not a drain on national resources but a pre-requisite for economic and social progress."[2] Welfare spending is not a wasteful inefficient diversion from the real economy: it is part of a counry's necessary economic base.

These countries need to repudiate their debts, recapture their national independence, and control their own economies. Only thus can they reduce poverty and so reduce ill health. As for our role, we can require those who wield power to get off the backs of the people of the developing nations.

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1 Wakhweya AM. Structural adjustment and health. *BMJ* 1995;311:71-2. (8 July.)
2 World Health Organisation. *Bridging the gap.* Geneva: WHO, 1995.

Every extracontractual referral is a jewel

EDITOR,—Barbara Ghodse points out that extracontractual referrals are a cause of anxiety in purchasing authorities, mainly because they have the potential to generate unpredictable expenditure on top of major service contracts.[1] We suggest that instead of regarding extracontractual referrals as a labour intensive drain on finance, purchasers should recognise that they are a potentially rich and convenient source of clinical information. They can be used as a simple method of quality audit if they are viewed as an index of dissatisfaction with services available under current contracts.

In the County Durham Health Commission, identification of changes in the pattern of extracontractual referrals has resulted in active interventions aimed at improving the range, quality, or appropriateness of contracted services. For instance, a rising trend in referrals for bone mass densitometry was an indication of demand by general practitioners for an investigation which was being widely promoted in the area and which required guidance for use. The emergence and increase in the number of extracontractual referral requests for paclitaxel in the treatment of gynaecological cancer highlights the need for a purchasing policy on the handling of expensive new drugs.